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Question 1 of 20

A 45-year-old man is referred with reduced energy levels, difficulty sleeping and low mood, symptoms he has been experiencing for several months. His wife divorced him last year on grounds of unreasonable behaviour, when he became withdrawn and refused to do anything around the house after losing his job.

On further questioning, he also admits to hearing voices telling him that he is useless.

What is the most likely diagnosis?

- A Depression
- B Personality disorder
- C Manic depression
- D Schizophrenia
- E Phobic anxiety

70731

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Explanation



A

Depression

This patient suffers key symptoms of depression such as persistent low energy levels, and low mood (for greater than at least two weeks) as described by the ICD-10. He also suffers associated symptoms of sleep disturbance. He has psychotic elements to his illness as evidenced by auditory hallucinations in the second person, which can occur in affective disorders. The constellation of these symptoms makes depression the most likely answer.

B

Personality disorder

A personality disorder is defined by the ICD-10 as a condition of 'deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations'. As this patient's symptoms are consistent with depression and he has no history of any prior behavioural disturbance, the diagnosis of personality disorder is not likely.

C

Manic depression

The patient does have symptoms consistent with depression; however, with no prior history of mania or hypomania, a diagnosis of bipolar affective disorder is not warranted.

D

Schizophrenia

The patient does suffer from auditory hallucinations; however, these can occur in depressive disorders and, alongside his other symptoms, depression is the most likely diagnosis. The ICD-10 in their diagnostic criteria for schizophrenia advise that auditory hallucinations more likely to be suggestive of schizophrenia include: third-person hallucinations, running commentaries, voices discussing the patient between themselves or voices coming from some part of the body.

E

Phobic anxiety

The patient expresses no specific phobia or anxiety symptoms, making this diagnosis incorrect.

70731

Rate this question:



A 30-year-old man attends the Outpatient Clinic. He has an obsession with washing his hands and spends up to one hour doing this each morning and evening. He says he feels that he is dirty. He is also concerned about security and checks the doors at home a number of times before leaving the house.

On examination, he is of low mood. He is slowed up in speech but coherent.

Which of the follow diagnoses fit best with this clinical picture?

- | | |
|---|-------------------------------|
| A | Acute schizophrenia |
| B | Major depressive illness |
| C | Obsessive-compulsive disorder |
| D | Bipolar affective disorder |
| E | Anxiety neurosis |

70732

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On examination, he is of low mood. He is slowed up in speech but coherent.

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Your answer was correct

- A Acute schizophrenia
- B Major depressive illness
- C Obsessive-compulsive disorder**
- D Bipolar affective disorder
- E Anxiety neurosis

Explanation



C Obsessive-compulsive disorder

Given this clinical picture of repetitive behaviour that is intrusive and consumes a significant amount of time during the day, OCD appears to be the most likely diagnosis. Associated depression is quite possible and is related to inability to overcome the repetitive cycles of behaviour. The incidence of OCD may be as high as 1-2% of the adult population and the condition occurs with roughly equal sex

Explanation

**C****Obsessive-compulsive disorder**

Given this clinical picture of repetitive behaviour that is intrusive and consumes a significant amount of time during the day, OCD appears to be the most likely diagnosis. Associated depression is quite possible and is related to inability to overcome the repetitive cycles of behaviour. The incidence of OCD may be as high as 1-2% of the adult population and the condition occurs with roughly equal sex incidence. Cognitive therapy or selective serotonin reuptake inhibitors are effective treatments.

A**Acute schizophrenia**

This patient is coherent, and does not present with classical thought disorder, auditory hallucination or delusions associated with acute schizophrenia. His obsessive symptoms are much more in keeping with a diagnosis of OCD.

B**Major depressive illness**

The patient does have slowed speech and appears low in mood, making it likely he is suffering from an element of concomitant depression; however, his obsessive symptoms best fit the clinical picture of OCD.

D**Bipolar affective disorder**

This patient has no historical or current symptoms of mania or hypomania, and therefore a diagnosis of bipolar affective disorder is not warranted.

E**Anxiety neurosis**

Symptoms of anxiety, such as tension, worry and feelings of apprehension, are not described in this vignette, and his obsessive symptoms are much more in keeping with a diagnosis of OCD.

70732

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**Next Question**

A 72-year-old man had been started on a selective serotonin reuptake inhibitor (SSRI) by his GP after presenting with symptoms of depression. He had responded well to treatment, but 3 months later returns to see you.

He is worried about things he has read in the newspaper saying that this medication could be harmful - in particular, that it may cause suicidal thoughts.

What should you do about his current antidepressant medication?

- A Reassure and continue current treatment
- B Reduce dose by 50%
- C Refer to psychiatrist
- D Change to tricyclic antidepressant
- E Stop antidepressant treatment

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Your answer was correct

A Reassure and continue current treatment

B Reduce dose by 50%

C Refer to psychiatrist

D Change to tricyclic antidepressant

E Stop antidepressant treatment

Explanation



A Reassure and continue current treatment

SSRI is a first-line treatment for depression and is an appropriate agent to use in this patient. The fact that he is responding well further supports your decision to use this treatment. There are some case reports linking increased suicidal thoughts, though not suicidal acts, to SSRIs in teenagers and young adults, and this has been occasionally misreported or sensationalised in the media. There is no clear evidence of this in adults over 18 years of age. In this case, it is best to reassure the patient and continue his SSRI treatment to which he is responding (see weblink below).



Explanation

A Reassure and continue current treatment

SSRI is a first-line treatment for depression and is an appropriate agent to use in this patient. The fact that he is responding well further supports your decision to use this treatment. There are some case reports linking increased suicidal thoughts, though not suicidal acts, to SSRIs in teenagers and young adults, and this has been occasionally misreported or sensationalised in the media. There is no clear evidence of this in adults over 18 years of age. In this case, it is best to reassure the patient and continue his SSRI treatment to which he is responding (see weblink below).

SSRIs are suitable for the vast majority of patients with depression. In a small number of cases it has been suggested that they may be linked to psychomotor agitation in the initial few days after commencing treatment. In addition, some patients may experience a return of symptoms after treatment withdrawal, so that abrupt cessation of treatment is not recommended. Significantly, patients who discontinue treatment after 3 months are at significantly higher risk of relapse. Tricyclic antidepressants would be associated with significantly more side effects, particularly in this age group.

B Reduce dose by 50%

This patient is responding well to treatment and doesn't complain of any side effects. There is no indication to change his dose at this point. Gradual tapering of an SSRI is usually indicated when preparing to discontinue the drug, or when switching to another antidepressant medication.

C Refer to psychiatrist

The patient has a simple query that can be managed in primary care. Minor to moderate depression can be managed in the community by a general practitioner with a combination of pharmacological and psychological treatments. Reasons to refer would be if the diagnosis is unclear, failing to respond to treatment or rapid worsening of symptoms.

D Change to tricyclic antidepressant

The patient is responding to his SSRI treatment, and therefore a switch to a tricyclic antidepressant (TCA) is not indicated. Even if the patient was failing to respond to an SSRI in terms of his depressive symptoms, an alternative SSRI would be the most likely second agent to switch to rather than a TCA treatment, which generally has more side effects (especially in an older person).

You are called to the Geriatric Psychiatry Ward to assess a new inpatient. A 66-year-old man was admitted yesterday for elective investigation of cognitive dysfunction. His wife describes a background of worsening memory problems and poor mobility. The pattern is one of 'good days' with minimal symptoms, followed by periods of sudden deterioration.

Calculate

Normal Va

In the weeks prior to admission, he has suffered frequent falls. He has no psychiatric history, although he has recently complained of fleeting visual hallucinations. He had no regular medication prior to admission.

On the night of his admission, he became acutely distressed, complaining of 'seeing monsters' in his peripheral vision. His agitation was such that he required emergency sedation.

On examination, he is drowsy and unable to give a coherent history. Tone is increased in all four limbs, although power seems normal. He has symmetrical upper limb rigidity and bradykinesia. His wife claims the involuntary movements are new.

What is the most appropriate management for the underlying neurological condition that has precipitated his admission to hospital?

- A Selective serotonin reuptake inhibitor
- B Acetylcholinesterase inhibitors
- C Aspirin and statins
- D Copper-chelating agents
- E Dopamine agonists

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Submit

Previous Q...

Skip Questi...

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- | | |
|----------|--|
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| B | Acetylcholinesterase inhibitors |
| C | Aspirin and statins |
| D | Copper-chelating agents |
| E | Dopamine agonists |

Explanation



- | | |
|----------|--|
| B | Acetylcholinesterase inhibitors |
|----------|--|

This patient's underlying diagnosis is very suggestive of

Difficulty: Av

Peer Response



Session Progress

Responses Correct

Responses Incorrect

Responses Total

Responses - % Correct

A 72-year-old woman visits the clinic feeling low. She has been feeling down for some time, and believes the problem has been confounded by an overactive bladder, previously assessed by the urology team, meaning that she is up and down to the toilet about ten times a day.

Calcu

Normal

On further questioning, she admits that she is apprehensive most of the day, and cannot relax. She lives alone, her husband died five years ago and the only company she has is her cat. She has lost 5 kg in weight over the past year and wakes up at around 0430-0500 h.

Clinical examination is unremarkable.

Given the likely diagnosis, which of the following represents the most appropriate therapy for this woman?

- A Oxybutynin
- B Sertraline
- C Dothiepin
- D Tolterodine
- E Amitriptyline

70736

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Previous Q...

Skip Questi...

Keeping with either of these diagnoses, and therefore this would not be the most appropriate agent to use in his management.

C Aspirin and statins

This combination would be appropriate for a patient suffering from vascular dementia, a dementing illness caused by series of repeated cerebral infarctions, usually in the context of risk factors such as hypertension. The disease manifests in a step-wise manner, and so periods of stability between deterioration can appear as the fluctuant stage of DLB. Neurological symptoms may also occur in vascular dementia, making these conditions difficult to differentiate. However, the patient's tetrad symptoms of dementia, fluctuant course, parkinsonism and visual hallucination point more towards a diagnosis of DLB.

D Copper-chelating agents

Wilson's disease, which is treated with copper-chelating agents, is a genetic disorder of copper metabolism that results in copper accumulation in body tissues, particularly the liver, brain, eyes and kidneys, and can present with neuro-psychiatric symptoms, including parkinsonism symptoms. However, it will usually also present with symptoms of liver disease and the classical Kayser-Fleischer rings on eye exam. The disease is most commonly diagnosed between the ages of 5 and 35 years.

E Dopamine agonists

Acetylcholinesterase inhibitors can be seen as a first-line treatment in DLB as they can have an improvement on neuropsychiatric and motor symptoms. Dopamine agonists such as ropinirole and rotigotine are used in the treatment of Parkinson's disease. For the severe parkinsonian symptoms of DLB, dopamine agonists have been used but they have been associated with worsening psychotic and behavioural symptoms. For this reason, small doses of levodopa are generally the preferred treatment for motor symptoms, as this agent has a lower side effect profile.

20735

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Explanation



B Acetylcholinesterase inhibitors

This patient's underlying diagnosis is very suggestive of dementia with Lewy bodies (DLB). This is a neurodegenerative disease caused by deposition of Lewy bodies (abnormal protein aggregates) in the cerebral cortex and brain stem. The consortium on DLB international workshop diagnostic criteria suggests the diagnosis is likely if, in the context of dementia, there are also present two of the three following core features: fluctuating attention and concentration, recurrent well-formed visual hallucinations and spontaneous parkinsonian motor signs. Further suggestive features include rapid eye movement (REM) sleep behaviour disorder, and a severe sensitivity to the extra-pyramidal side effects of neuroleptics. There is some evidence in the form of a small number of randomised controlled trials and open label studies to suggest that acetyl cholinesterase inhibitors, such as rivastigmine, may reduce hallucinations, fluctuations and parkinsonian symptoms and improve attention.

A Selective serotonin reuptake inhibitor

Selective serotonin reuptake inhibitors are a class of antidepressant drugs that are typically used to treat depression and anxiety. This patient's presentation is not in keeping with either of these diagnoses, and therefore this would not be the most appropriate agent to use in his management.

C Aspirin and statins

This combination would be appropriate for a patient suffering from vascular dementia, a dementing illness caused by series of repeated cerebral infarctions, usually in the context of risk factors such as hypertension. The disease manifests in a step-wise manner, and so periods of stability between deterioration can appear as the fluctuant stage of DLB. Neurological symptoms may also occur in vascular dementia, making these conditions difficult to differentiate. However, the patient's tetrad symptoms of dementia, fluctuant course, parkinsonism and visual

B Sertraline

This lady is complaining of low mood and anxiety symptoms. She has somatic symptoms of depression including weight loss and early morning waking, as well as symptoms of anxiety such as apprehension and an inability to relax. The most appropriate treatment for these symptoms would be a selective serotonin reuptake inhibitor (SSRI) in the first instance. Possible second-line agents to treat her symptoms would include the tricyclic antidepressants (TCAs) dothiepin and amitriptyline; however, bear in mind their anticholinergic side-effect profile could worsen her urinary symptoms by causing retention or obfuscating future urinary investigation.

A Oxybutynin

Oxybutynin is an anticholinergic medication that can be used to treat symptoms of urinary frequency or urgency. This medication may help the patient's urinary symptoms, but it will not treat any symptoms of low mood and anxiety - the reasons why this lady attended clinic initially.

C Dothiepin

In accordance with NICE guidelines, TCAs are not the first-line treatment of anxiety or depressive symptoms. They are an effective treatment for these symptoms, but their higher toxicity profile makes an SSRI a more appropriate agent to use as a primary treatment choice. Additionally, TCAs may further disturb the patient's urinary symptoms.

D Tolterodine

Tolterodine is an antimuscarinic agent that can be used as a treatment for detrusor overactivity. It could potentially be used to treat this patient's symptoms of urinary frequency, but would not treat her symptoms of low mood and anxiety for which she had initially attended the clinic.

E Amitriptyline

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A 62-year-old man, with a past medical history of hypertension, comes to the Emergency Department with his daughter, who is very concerned that he may be depressed.

Calc

Normal

He wakes very early in the morning, has been complaining of low mood and energy levels and seems not to have been eating for the past few weeks. Apparently, he has undergone some minor investigations for indigestion, which have proved unremarkable apart from some minor gastro-oesophageal reflux disease for which his GP has prescribed low-dose PPI.

On review, you become quite concerned because he tells you the reason he is depressed is that he thinks he is dying from stomach cancer and he has considered taking a paracetamol overdose (over the past two days), but has been dissuaded from doing this by his daughter.

Investigations:

Hb	12.1 g/dl
WCC	$4.9 \times 10^9/l$
PLT	$175 \times 10^9/l$
Na ⁺	141 mmol/l
K ⁺	4.2 mmol/l
Creatinine	100 μ mol/l

Which of the following would be the most appropriate therapy choice for him?

A	Psychoanalysis
B	Amitriptyline
C	Electroconvulsive therapy
D	Citalopram
E	Venlafaxine

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Which of the following would be the most appropriate therapy choice for him?

Your answer was incorrect

- A Psychoanalysis
- B Amitriptyline
- C Electroconvulsive therapy

Explanation

D Citalopram

This patient is suffering from moderate to severe depression, as evidenced by his symptoms of low mood, low energy, anorexia, early morning waking and suicidal ideation. ICD-10 lists 10 main symptoms of depression, with the three core symptoms being (1) persistent sadness or low mood, (2) loss of interests or pleasure and (3) fatigue or low energy; and the others being (4) disturbed sleep, (5) poor concentration, (6) low self-confidence, (7) poor appetite, (8) suicidal thoughts, (9) psychomotor agitation or retardation and (10) guilt or self-blame. Moderate depression is described as five or more symptoms, and severe as seven or more. This patient is also suffering a negative delusion regarding a diagnosis of cancer. The first-line pharmaceutical treatment for this illness would be citalopram, an SSRI, as per NICE guidelines.

C Electroconvulsive therapy

The first-line treatment of moderate to severe depression is an SSRI. Electroconvulsive therapy (ECT) is used in the UK for the rapid treatment of severe depression when it is life threatening or when it has failed to respond to other treatments. It is also used to treat resistant mania and catatonia.

A Psychoanalysis

This patient is suffering from moderate to severe depression. Psychological interventions are recommended as part of illness management, but cognitive behavioural therapy or interpersonal therapy is the mainstay of psychological treatment, rather than psychoanalysis.

B Amitriptyline

NICE guidelines recommend a selective serotonin reuptake inhibitor (SSRI) as a first-line treatment in moderate to severe depression, making this answer, amitriptyline, a TCA (tricyclic antidepressant) incorrect. TCAs have a higher toxicity profile and are potentially more harmful than SSRIs in an overdose scenario. They are also more likely to interact with medications that an older patient may be taking concurrently.

E Venlafaxine

Venlafaxine is a serotonin-norepinephrine reuptake inhibitor (SNRI) used in the treatment of depression. SSRIs remain the first-line treatment of depression in accordance with Nice Guidelines. Venlafaxine is listed as a drug to be used with caution in those suffering from hypertension, another reason why it might not be an appropriate treatment option for this patient.

An 18-year-old girl is admitted to the Emergency Department after slashing at her arms with a kitchen knife. She has had episodes of paracetamol overdose in the past, and says that this time was because of a row with her boyfriend.

Calcula

Normal V

Currently, she finds it difficult to hold down a job and has been in trouble with the police for alcohol abuse. She lives alone, having moved out of the family home due to domestic violence.

On examination, there are multiple, healed scars due to previous wrist and arm slashing. She is abusive and tearful but is otherwise normal.

Which of the following is the most likely diagnosis?

- | | |
|---|---------------------------------|
| A | Depression |
| B | Schizophrenia |
| C | Borderline personality disorder |
| D | Bipolar disease |
| E | Post-traumatic stress disorder |

70738

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Previous Q...

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An 18-year-old girl is admitted to the Emergency Department after slashing at her arms with a kitchen knife. She has had **episodes of paracetamol overdose** in the past, and says that this time was because of a row with her boyfriend.

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Which of the following is the most likely diagnosis?

Your answer was correct

- | | |
|---|---------------------------------|
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| B | Schizophrenia |
| C | Borderline personality disorder |
| D | Bipolar disease |
| E | Post-traumatic stress disorder |

Explanation



C Borderline personality disorder

Borderline or emotionally unstable personality disorder is a disorder characterised by an unpredictable and capricious mood, emotional outbursts and impulsivity. There is usually instability of interpersonal relationships, intense fear of abandonment, self-harm and suicidal gesture. The patient's behaviour is in keeping with a diagnosis of borderline personality disorder. Treatment usually involves risk assessment and psychological and behavioural interventions.

A Depression

Difficulty: 4

Peer Response



Session Progress

Responses Correct

Responses Incorrect

Responses Total

Responses - % Correct



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E Post-traumatic stress disorder

Explanation



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A Depression

Although this patient appears tearful and has evidence of self-harm, there are no other symptoms to suggest a depressive illness, and in fact, her social, forensic and relationship histories are more suggestive of an enduring disorder of the personality.

B Schizophrenia

There is no history here of hallucination, delusion or thought disorder that would suggest a diagnosis of schizophrenia.

D Bipolar disease

There is no history here of previous depressive or manic symptoms, which may include increased talkativeness, grandiosity, psychomotor acceleration or distractibility, and so a diagnosis of bipolar disease is not warranted.

E Post-traumatic stress disorder

There is no suggestion in the vignette of a stressor that has caused the patient distress of a pervasive nature, and no history of the patient 'reliving' the stressor (i.e. via dreams, flashbacks). The predominant symptoms of interpersonal difficulty, self-harm and emotional outbursts point more towards a diagnosis of borderline personality disorder.

70738

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Next Question

A 54-year-old woman with long-standing schizophrenia is admitted to the Emergency Department with pyrexia and decreased conscious level. Her home help reports that she has been increasingly thirsty over the past few weeks and seems to be drinking increasingly large amounts of tea, and is requesting a number of bottles of Coke as part of the weekly shop. She has struggled with her weight for many years, and has a history of hypertension for which she takes ramipril.

Calcula

Normal V

On examination, her Glasgow Coma Scale (GCS) score is 11. Her BP is 124/80 mmHg and her pulse is 100/min.

Investigations:

Hb	13.2 g/dl
WCC	$11.1 \times 10^9/l$
PLT	$247 \times 10^9/l$
Na ⁺	146 mmol/l
K ⁺	5.9 mmol/l
Creatinine	230 μ mol/l
Bicarbonate	23 mmol/l
Glucose	41.2 mmol/l

Which of the following medications is most likely to have contributed to her presentation?

- A Flupenthixol
- B Haloperidol
- C Risperidone
- D Fluoxetine
- E Clozapine

70730

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E Clozapine

Atypical antipsychotics are associated with a risk of developing type 2 diabetes. A study by Nielsen et al. (see below) found that type 2 diabetes occurred most commonly with clozapine (odds ratio (OR) 2.37) and olanzapine (OR 1.57). It is thought that olanzapine and clozapine lead to increased weight gain and insulin resistance, and this may accelerate the development of impaired glucose tolerance and diabetes. Antagonism at the 5-HT_{2C} and H₁ receptors seems to be involved in antipsychotic-induced weight gain. Among the antipsychotics, clozapine and olanzapine, which have the highest weight gain/obesity risk, also have the highest affinities for 5-HT_{2C} and H₁ receptors.

A Flupenthixol

This lady has hyperglycaemia and polydipsia, suggesting the development of diabetes. Flupenthixol is a typical antipsychotic whose main side effects include extrapyramidal and anti-muscarinic symptoms. It may cause hyperglycaemia and the development of diabetes, but nowhere near at the same frequency as clozapine and other atypical antipsychotics.

B Haloperidol

Haloperidol is a typical antipsychotic whose main side effects include extrapyramidal and anti-muscarinic symptoms. It may cause hyperglycaemia and the development of diabetes, but nowhere near at the same frequency as clozapine and other atypical antipsychotics.

C Risperidone

The use of atypical antipsychotics is associated with the development of diabetes. However, risperidone is seen as one of these drugs with a lower risk of causing diabetes.

D Fluoxetine

Fluoxetine is a selective serotonin reuptake inhibitor (SSRI) and is not associated with significant risk of developing diabetes.

70752

Rate this question: **Next Question**

A 56-year-old woman with chronic back pain is reviewed at the pain clinic. The doctor who reviews her is concerned that there may be an element of depression that is worsening her symptoms, and decides to prescribe citalopram. However, she returns to the Emergency Department the following day feeling agitated and unwell.

Calcula

Normal V

On examination, she has globally increased rigidity and tremor. She is confused and agitated when questioned about her symptoms. Her temperature is elevated at 37.8 °C, her BP is 155/92 mmHg, with a RR of 25 and a pulse of 100/min.

Investigations:

Hb	13.2 g/dl
WCC	$6.9 \times 10^9/l$
PLT	$190 \times 10^9/l$
Na ⁺	141 mmol/l
K ⁺	5.1 mmol/l
Creatinine	130 μ mol/l
Urea	13.2 mmol/l

Which of the following is the most likely diagnosis?

- A Tardive dyskinesia
- B Serotonin syndrome
- C Tramadol toxicity
- D Attention seeking behaviour
- E Encephalitis

70740

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Previous Q...

Skip Questi...

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Investigations:

Hb	13.2 g/dl
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Which of the following is the most likely diagnosis?

Your answer was correct

- A Tardive dyskinesia
- B Serotonin syndrome**
- C Tramadol toxicity

B Serotonin syndrome

Serotonin syndrome is characterised by agitation, hyperthermia, tachycardia, labile blood pressure, hyper-reflexia and increased tone. It may be caused by any of the drug classes that result in increased serotonin, e.g. selective serotonin reuptake inhibitors (SSRIs) or monoamine oxidase inhibitors, and symptoms usually occur in close proximity to initiation of one of these drugs. Removal of the causative agent and supportive therapy, which may include administration of benzodiazepines, are the mainstay of treatment. Some case reports suggest that non-specific serotonin antagonists such as chlorpromazine may be helpful in some cases. Symptoms usually resolve over a period of 24–36 h.

A Tardive dyskinesia

Tardive dyskinesia describes the rapid, involuntary facial movements, and sometimes limb movements, associated with typical antipsychotics, and to a lesser extent the atypical antipsychotics and the anti-emetic, metoclopramide. It does not usually present with an acute destabilisation of the patient's vital signs as in this vignette.

C Tramadol toxicity

This lady may have accidentally overdosed on an opiate medication such as tramadol for her back pains, but symptoms of opiate toxicity - including reduced respiratory rate and constricted pupils - are not described. Opiate overdose can cause agitation and euphoria, but usually results in reduced mentation and drowsiness. Opiate toxicity may be associated with a small drop in blood pressure rather than hypertension, and is not associated with pyrexia.

D Attention seeking behaviour

This patient is confused with unstable observations, deranged renal function and recent initiation of a new medication, making this diagnosis incorrect.

E Encephalitis

Encephalitis can present with altered mental state and pyrexia, and there may also be focal neurological signs such as seizure activity. The clue in this vignette is the proximity of her SSRI treatment to the development of her symptoms, making the diagnosis of serotonin syndrome more likely.

A 53-year-old man with long-standing schizophrenia is referred by his GP after three fasting blood glucoses of 11.2, 17.3 and 9.2 mmol/l during the same month. He is taking a number of anti-psychotic and anti-depressive medications. On examination his BP is 142/74 mmHg and his BMI is 32. Other physical examination is unremarkable.

Calcu

Normal

Investigations:

Hb	12.9 g/dl
WCC	$5.9 \times 10^9/l$
PLT	$190 \times 10^9/l$
Na ⁺	140 mmol/l
K ⁺	4.7 mmol/l
Creatinine	110 μ mol/l
Glucose	9.2 mmol/l

Which one of the following medications should be avoided in the management of his condition as it may worsen his glucose tolerance?

- A Citalopram
- B Risperidone
- C Olanzapine
- D Amytriptline
- E Fluoxetine

70741

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Previous Q

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C

Olanzapine

Olanzapine as an atypical anti-psychotic which has been shown in studies to be associated with increasing risk of developing type 2 diabetes with increasing dose; this is related to weight gain, insulin resistance and subsequent impaired glucose tolerance. A large study of real-life use of olanzapine suggested it was associated with an odds ratio of 3.1 for the development of type 2 diabetes.

Reference: Differential effects of risperidone, olanzapine, clozapine, and conventional antipsychotics on type 2 diabetes: findings from a large health plan database. Frank D. Gianfrancesco, Amy L. Grogg, Ramy A. Mahmoud, Ruey-hua Wang, Henry A. Nasrallah. *J Clin Psychiatry* 2002; 63(10):920-30.

A

Citalopram

Although use of SSRIs may promote weight gain, this isn't as marked as the weight gain seen with agents such as olanzapine and isn't associated with dysglycaemia in the majority of cases.

B

Risperidone

In the same epidemiological analysis as that for olanzapine, the odds ratio for developing type 2 diabetes was 0.88. Clozapine appears to be associated with the highest risk of development of type 2 diabetes (OR 7.44).

D

Amitriptyline

Tricyclic anti-depressants are usually considered when patients also have significant sleep disorder as they are sedating. They aren't recognised to cause increased risk of diabetes mellitus.

E

Fluoxetine

Like citalopram it isn't associated with increased risk of diabetes development.

TOTAL

Rate this question: 

Next Question

A 57-year-old man is brought to the Emergency Department by his wife. He tells you that he is already dead and is in hell, that he does not exist in this world.

Calcu

His wife tells you that he barely eats, sleeps for long periods in the day and wakes in the early hours of the morning. She says he became preoccupied and very low in mood after some problems at work. Most recently, he had tried to jump out of the car whilst they were driving to the hospital.

Normal

On examination, he stares continuously at the floor, mumbling only that he is in hell, the devil is on him and he's already dead. He looks unkempt and as if he has not been taking good care of himself.

Investigations:

Hb	13.1 g/dl
WCC	$4.5 \times 10^9/l$
PLT	$201 \times 10^9/l$
Na ⁺	139 mmol/l
K ⁺	4.9 mmol/l
Creatinine	110 μ mol/l
TSH	3.9 U/l

Which of the following treatments is most likely to be effective in this case?

A	Amitriptyline
B	Fluoxetine
C	Citalopram
D	ECT
E	Haloperidol

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Creatinine	110 μ mol/l
TSH	3.9 U/l

Which of the following treatments is most likely to be effective in this case?

Your answer was correct

A Amitriptyline

B Fluoxetine

C Citalopram

D ECT

Difficulty

Peer Res



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Responses Tot

Responses - %



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C Citalopram

D ECT

E Haloperidol

Explanation



D ECT

This man has delusional depression, with features consistent with Cotard syndrome, where patients have a belief that they have actually died and no longer really exist. Symptoms consistent with severe depression include the early morning waking and daytime somnolence and his poor appetite. In delusional depression, tricyclic antidepressants, SSRIs and major tranquillisers are less successful than ECT, which in this patient is likely to have rapid, positive impact on his symptoms.

A Amitriptyline

In delusional depression, amitriptyline as monotherapy is not usually considered effective; it may be more effective in relieving symptoms when combined with an anti-psychotic.

B Fluoxetine

In this situation, SSRIs may be ill-advised because they increase agitation during the initial stages of therapy, thus potentially increasing the risk of suicide.

C Citalopram

Like fluoxetine, citalopram is potentially best avoided in the initial stages of treatment for this patient because of the risk of increasing agitation.

E Haloperidol

In the event that anti-psychotics are used to manage delusions in patients with this form of depression, they are usually combined with a second anti-depressant medication.

70742

Rate this question:



A 32-year-old woman with a history of severe bipolar disorder treated with lithium is in the midst of an extended period of psychotic depression.

Calc

She tells you that she has thought about suicide and had begun drafting a suicide note, but threw it away the preceding week, and that she was considering a number of methods and had researched them on the Internet.

Norma

She does not want to be admitted and tells you she will try to be compliant with drug therapy.

Which of the following regimes for her would carry the least risk in overdose?

- A Lithium and fluoxetine
- B Lithium and sodium valproate
- C Lithium
- D Sodium valproate
- E Amitriptyline

70743

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D Sodium valproate

E Amitriptyline

Explanation

**D Sodium valproate**

Sodium valproate overdose is rarely fatal, with a case fatality rate of only around 0.2% in a US case series. CNS depression is seen with hypotension and lactic acidosis in severe overdose. Repeat-dose activated charcoal may be given and haemodialysis may be considered in patients with very high valproate levels.

A Lithium and fluoxetine

Although lithium and fluoxetine given in combination may be very effective in treating refractory depression, lithium carries significant risk in overdose and should therefore be avoided here.

B Lithium and sodium valproate

Taken together in overdose, lithium and sodium valproate carry significant risk, particularly with respect to synergistic effects on CNS depression.

C Lithium

Even when used as monotherapy, lithium carries significant risk of CNS toxicity and renal impairment in acute overdose. Haemodialysis is considered when levels of lithium breach 4 mmol/l and there is evidence of renal impairment, or when levels breach 5 mmol/l, even in the absence of kidney disease.

E Amitriptyline

A number of deaths occur each year due to tricyclic anti-depressant overdose, particularly when taken with alcohol. Metabolic acidosis, QT prolongation and ventricular arrhythmias are common sequelae.

TD743

Rate this question:      **Next Question**

An 18-year-old woman is transferred from the Intensive Psychiatric Care Unit. She was admitted with a four-week history of auditory hallucinations and paranoid ideation. At the time of admission, she was verbally and physically aggressive, limiting any physical examination. She remained difficult to manage all that day and needed rapid tranquilisation.

Two days later, she was found to be pyrexial, with tachycardia and tachypnoea, and was transferred to the Medical Unit for further investigation.

The patient is drowsy and no history is available. On examination, core temperature is 40 °C, pulse 110/min regular, blood pressure labile. She has lead pipe rigidity in all four limbs. There is no meningism, no papilloedema and plantar responses are flexor.

Investigations:

Urea	12 mmol/l
WCC	$15 \times 10^9/l$
Creatinine	155 $\mu\text{mol/l}$
PLT	$700 \times 10^9/l$
CSF	Normal biochemistry, nil on Gram stain
Urine dipstick	Blood +++
Urinalysis	Nil
Chest X-ray	Clear lung fields

Blood cultures have been sent from the unit before her transfer.

What is the investigation most likely to contribute to making the diagnosis?

- A EEG
- B CT brain
- C Serum and urinary porphyrins
- D Serum CK
- E Serum amylase

An 18-year-old woman is transferred from the Intensive Psychiatric Care Unit. She was admitted with a four-week history of **auditory hallucinations and paranoid ideation**. At the time of admission, she was verbally and physically aggressive, limiting any physical examination. She remained difficult to manage all that day and needed rapid tranquilisation.

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Your answer was correct

A EEG

B CT brain

Difficulty

Peer Res



Session

Responses Co

Responses Inc

Responses Tot

Responses - %

Explanation



D Serum CK

The most likely diagnosis here is neuroleptic malignant syndrome and subsequent rhabdomyolysis. This is most often associated with older neuroleptic agents, although it can be caused by any drug with dopamine antagonist properties. Treatment is supportive, with antipyretics, fluid resuscitation and autonomic monitoring. Bromocriptine is now thought to be of most value (and preferable to dantrolene) in severe cases. The laboratory results given are typical of developing rhabdomyolysis. The positive dipstick and negative urine microscopy are suggestive of myoglobinuria. Measurement of creatine kinase (CK) will help confirm the diagnosis.

A EEG

Although non-convulsive status may be a possibility, it is less likely than neuroleptic malignant syndrome given the other findings seen here, such as labile blood pressure and pyrexia.

B CT brain

CT brain may show cerebral oedema as a cause of decreased consciousness, but it won't reveal the underlying cause.

C Serum and urinary porphyrins

Acute intermittent porphyria presents with episodes of abdominal pain, hypertension and anxiety/agitation. The auditory hallucinations and paranoid ideation would be inconsistent with AIP, as would other signs such as the haematuria seen on dipstick.

E Serum amylase

The haematuria seen here on dipstick analysis and the absence of abdominal pain or vomiting are very inconsistent with a diagnosis of acute pancreatitis.

TC744

Rate this question: 

You assess a 74-year-old woman at the Neurology Clinic who has been referred with memory loss. The patient is a difficult historian, answering most questions with 'yes' or 'no'. You manage to elicit a story of subacute onset memory difficulty. The patient describes herself as 'stupid'. She further volunteers symptoms of intermittent headache, abdominal pain and insomnia.

Calc

Norma

There is a family history of ischaemic heart disease, and her sister has recently died from a myocardial infarction. The referral letter describes gradual social withdrawal, such that the patient has been refusing to attend the general practitioner's surgery. Her doctor is also concerned about poor appetite and gradual weight loss.

Physical examination, including BP of 135/82 mmHg and pulse of 75/min and regular, is unremarkable. Her BMI is 23. She does not comply with formal mental state testing.

What initial management is indicated?

- A Lithium
- B Aspirin, statin and ACE inhibitor
- C Donepezil
- D Therapeutic lumbar puncture
- E Citalopram

70745

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Previous Q...

Skip Questi...

You assess a 74-year-old woman at the Neurology Clinic who has been referred with memory loss. The patient is a difficult historian, answering most questions with 'yes' or 'no'. You manage to elicit a story of subacute onset memory difficulty. The patient describes herself as 'stupid'. She further volunteers symptoms of intermittent headache, abdominal pain and insomnia.

There is a family history of ischaemic heart disease, and her sister has recently died from a myocardial infarction. The referral letter describes gradual **social withdrawal**, such that the patient has been refusing to attend the general practitioner's surgery. Her doctor is also concerned about **poor appetite and gradual weight loss**.

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- A Lithium
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Explanation



E Citalopram

Although the general practitioner was concerned about a neurodegenerative process, the clinical picture is more in keeping with a depressive 'pseudo-dementia'. Note the subjective complaint of memory loss, social withdrawal,

Difficulty

Peer Res



Session

Responses Co

Responses Inc

Responses Tot

Responses - %

Explanation



E

Citalopram

Although the general practitioner was concerned about a neurodegenerative process, the clinical picture is more in keeping with a depressive 'pseudo-dementia'. Note the subjective complaint of memory loss, social withdrawal, insomnia and poor appetite. There are a number of validated tools for measuring depression in the elderly. The Geriatric Depression Scale is often used in the UK. However, it has been shown that a simple question such as 'Are you depressed?' has a similar sensitivity for case detection. Exclusion of dementia with formal cognitive testing can be difficult. As shown in the above scenario, depressed patients may perform poorly for motivational reasons. In practice, if there is suspicion of depression, many clinicians will treat first and then reassess. There is no evidence of superiority of one anti-depressant in the elderly. The selective serotonin-reuptake inhibitor citalopram is often used because of an acceptable side effect profile and lack of interactions with other drugs. Secondary causes of depression should be considered. Alcohol and sedative use would be the most common; in a woman with disturbed sleep and weight gain, thyroid dysfunction should also be excluded.

A

Lithium

Lithium has a relatively unfavourable side effect profile in the elderly due to its narrow therapeutic range, potential nephrotoxicity and CNS depression. In the absence of evidence of bipolar disease versus depression alone, there is little to support its use.

B

Aspirin, statin and ACE inhibitor

Multi-infarct dementia presents with step-wise neurological deterioration, presumably due to discrete vascular events, rather than the gradual deterioration seen here. Hence, intensive management of cardiovascular risk factors isn't warranted in this case.

C

Donepezil

The refusal to comply with mental state testing rather than an established low score is more consistent with depression than dementia, although donepezil may be trialled if formal evidence of dementia is established later.

D

Therapeutic lumbar puncture

Therapeutic lumbar puncture is considered for patients with evidence of normal-pressure hydrocephalus who present with the triad of dementia, gait disturbance and urinary intoxication.

70745

Rate this question:



A 39-year-old woman presents to the First Seizure Clinic. She is accompanied by her community psychiatric nurse. The nurse provides a witness account of the attacks. Each episode has occurred in the community day hospital. The patient would fall to the floor screaming. She would then thrash around both her arms followed by her legs.

During the episodes, she is unresponsive, holding her eyes tightly shut. Afterwards, she is able to converse with staff in the centre. She has never injured herself, but often complains of headache post-event. The patient claims to have no memory of events.

Systems enquiry reveals no other symptoms.

Past medical history includes schizophrenia, well controlled on depot chlorpromazine. She is a lifetime smoker with mild airways disease. Physical examination reveals tar staining of fingers only.

Investigations:

Toxicology screen	Negative
Interictal electroencephalogram (EEG)	Formal report: 'Minor slowing of alpha waves, with increased voltage theta activity and diffuse fast activity'
Serum prolactin	900 IU/ml (59-619)

You reassure her that the seizures are unlikely to cause significant harm.

What other step would you advise?

- A Pregnancy testing
- B MRI pituitary fossa
- C Dynamic pituitary function testing
- D Lumbar puncture
- E Commence sodium valproate

70546

Submit

A 39-year-old woman presents to the First Seizure Clinic. She is accompanied by her community psychiatric nurse. The nurse provides a witness account of the attacks. Each episode has occurred in the community day hospital. The patient would fall to the floor screaming. She would then thrash around both her arms followed by her legs.

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- E Commence sodium valproate

Difficulty: A

Peer Response



Session Progress

Responses Correct

Responses Incorrect

Responses Total

Responses - % Correct



Pregnancy testing

In this case other causes of raised prolactin which may influence the choice of anti-psychotic medication, namely pregnancy, should be excluded.

MRI pituitary fossa

The elevation in prolactin seen here is very modest, and MRI of the pituitary risks diagnostic confusion because of identification of an abnormality which may have nothing to do with the current presentation.

Dynamic pituitary function testing

Given the very modest increase in prolactin and absence of symptoms of pituitary dysfunction, dynamic pituitary function testing isn't indicated.

Lumbar puncture

There are no indications of an infective or inflammatory cause for these episodes, meaning that lumbar puncture is not of value here.

Commence sodium valproate

Given that these are most likely non-epileptic seizures, there is no value in using sodium valproate in this patient. It may actually lead to adverse effects on her behaviour in the context of previous psychiatric illness.





A 23-year-old computer engineer presents to his GP with symptoms suggestive of a mixed anxiety-depression disorder. His GP prescribes fluoxetine 20 mg daily and alprazolam 0.25 mg per day. The following day, the patient presents to the Emergency Department accompanied by his mother. She explains that he has become unduly euphoric and hyperactive.

On examination, he appeared confused and had frequent sudden, brief jerking in various parts of his body. On further questioning about his drug history, he admitted to self-medication with St John's wort as well as his prescribed medication. He brings a urine specimen to the Emergency Department which is positive for blood.

Which of the following is the most likely diagnosis?

- A Serotonin syndrome
- B Myoclonic epilepsy
- C Neuroleptic malignant syndrome
- D Psychogenic non-epileptic seizures
- E Bipolar disorder

70747

Submit

Previous Q...

Skip Questi...

E Bipolar disorder

Explanation

**A Serotonin syndrome**

This patient has serotonin syndrome, an uncommon but potentially fatal complication of selective serotonin re-uptake inhibitors (SSRIs) especially when combined with other serotonin-enhancing agents, including tricyclic antidepressants, monoamine oxidase inhibitors and the herbal treatment St John's wort (hypericum). It develops over hours with characteristic hypomania, drowsiness, myoclonus, hyperthermia and pronounced autonomic symptoms (the 'happy drunk' state). It may resemble the neuroleptic malignant syndrome. Hyper-reflexia, not hyporeflexia, is typical. Conjunctival haemorrhage is not a typical feature. Support with IV fluid rehydration, and treatment of symptoms of anxiety with benzodiazepines are the therapies of choice.

B Myoclonic epilepsy

Myoclonic epilepsy presents for the first time in teenagers, and in the presence of potential precipitating factors such as use of SSRI and St John's wort, serotonin syndrome should be excluded first.

C Neuroleptic malignant syndrome

Neuroleptic malignant syndrome occurs in patients exposed to dopamine antagonists, rather than SSRIs.

D Psychogenic non-epileptic seizures

The discrete episodes of brief limb jerking coupled with confusion are more consistent with actual, rather than non-epileptic, seizures.

E Bipolar disorder

Bipolar disorder is associated with fluctuations between depression and hypomania/mania; the presentation here with intermittent seizures is inconsistent with bipolar disorder.

70747

Rate this question:      **Next Question**



An 18-year-old man is admitted to Accident and Emergency after collapsing in a night club. He is drowsy but oriented and able to answer questions. This was his first week at university and he had decided to go out to a night club with his friends. He was given some 'tablets' in the night club to make him more relaxed and he was advised to drink a lot of fluids. All he remembers was that he went onto the dance floor and everything blacked out. When he came round, he was lying on the floor with people standing all around him and then he was brought to the hospital.

On examination, his temperature was 37.1 °C, blood pressure was 140/85 mmHg and his pulse was 104 bpm and regular. Apart from being slightly drowsy, his neurological examination was essentially normal.

Investigations:

Hb	12.0 g/dl
WCC	$5.0 \times 10^9/l$
PLT	$200 \times 10^9/l$
Na ⁺	123 mmol/l
K ⁺	3.2 mmol/l
Creatinine	67 μ mol/l
Urea	1.8 mmol/l
MCV	90 fl

What is the most appropriate step in the immediate management of this patient?

- A Restrict fluid intake
- B Give dantrolene 1 mg/kg IV
- C IV hypertonic saline
- D Metoprolol 5-10 mg IV
- E Diazepam 0.1-0.3 mg/kg PO

70250

Submit

An 18-year-old man is admitted to Accident and Emergency after collapsing in a night club. He is drowsy but oriented and able to answer questions. This was his first week at university and he had decided to go out to a night club with his friends. He was given some 'tablets' in the night club to make him more relaxed and he was advised to drink a lot of fluids. All he remembers was that he went onto the dance floor and everything blacked out. When he came round, he was lying on the floor with people standing all around him and then he was brought to the hospital.

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Difficulty: Average

Peer Response



Session Progress

Responses Correct: 28

Responses Incorrect: 2

Responses Total: 30

Responses - % Correct: 93.3%

What is the most appropriate step in the immediate management of this patient?

Your answer was correct

- A Restrict fluid intake
- B Give dantrolene 1 mg/kg IV
- C IV hypertonic saline
- D Metoprolol 5-10 mg IV
- E Diazepam 0.1-0.3 mg/kg PO

Explanation



A Restrict fluid intake

E Diazepam 0.1-0.3 mg/kg PO

Explanation



A Restrict fluid intake

Ecstasy is the common usage name for 3,4-methylenedioxymethamphetamine, which is a psychoactive drug. It is a class A drug and is illegal in the UK. It is commonly used at dance parties and changes the mood through its effects on dopaminergic and serotonergic pathways. It has a short duration of action of about 4-6 h and is usually ingested in a dose of 75-150 mg orally.

Its effects are said to relax the users and make them more friendly to other people. Its side effects are unpredictable and include: nausea, sweating, hypertension, tachycardia, disseminated intravascular coagulation and liver failure. Deaths have been reported from heat stroke and water intoxication.

In this case, given the serum sodium, it is water intoxication which is the likely problem and fluid restriction is the intervention of choice.

B Give dantrolene 1 mg/kg IV

Dantrolene was formerly used as a treatment for malignant hyperthermia, although now anti-cholinergics are the usual preferred intervention of choice.

C IV hypertonic saline

Hypertonic saline is not required, given this patient's normal current neurological status. Only in the event that there was significant CNS depression with seizures would hypertonic saline, given in the ITU environment, be considered.

D Metoprolol 5-10 mg IV

Metoprolol is only required in the event of significant hypertension or SVT related to ecstasy use. It isn't therefore required here.

E Diazepam 0.1-0.3 mg/kg PO

This is the appropriate intervention where there is significant agitation or seizures associated with ecstasy use.

A 34-year-old builder is admitted with an acute inferior myocardial infarction and is immediately sent for percutaneous coronary intervention (PCI). His risk factors for ischaemic heart disease include smoking 40 cigarettes a day and hypercholesterolaemia. He is a heavy drinker but denies any illicit drug use.

Calculato

Normal Val

The following day, he becomes anxious, tachycardic and sweaty. His BP is 155/72 mmHg, with pulse 105 and regular. Although his ECG shows no new ischaemic changes, there is a lot of baseline interference due to the development of a tremor.

What is the appropriate next step in his management?

- A Return to the catheter lab
- B IV fluid loading
- C IV metoprolol
- D IV thrombolysis
- E Reducing course of oral benzodiazepines

70762

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C IV metoprolol

D IV thrombolysis

E Reducing course of oral benzodiazepines

Explanation



E Reducing course of oral benzodiazepines

The most likely diagnosis, given this patient's admission of significant alcohol consumption, is alcohol withdrawal. As such, the most appropriate intervention, with signs of anxiety and sympathetic activation, is a reducing course of oral benzodiazepines.

A Return to the catheter lab

Given there is no evidence of new ischaemia with an ECG showing now new changes, there is no reason to return to the catheter lab.

B IV fluid loading

IV fluid loading is optimal with respect to maintaining right ventricular filling pressure. Given that BP is well preserved here at 155/72, and there are no new ECG changes, there isn't an indication for fluid loading.

C IV metoprolol

Given that blood pressure is maintained with a pulse modestly increased to 105/min, and there are no indications of new ischaemia, there is no indication for IV metoprolol.

D IV thrombolysis

In the absence of new ischaemia, there is no reason to move to IV thrombolysis.

70753

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A 37-year-old man known to be in the early stages of Huntington's disease is admitted to the Emergency Department by ambulance. His wife found him unconscious on the floor with an empty bottle of codeine phosphate at his side. He had left a suicide note and on further questioning his wife admits that her husband has been depressed for a few weeks.

On examination, his Glasgow Coma Scale (GCS) score is 7, with a respiratory rate of 10/min and BP of 100/60 mmHg.

Investigations:

pH	7.25
pO ₂	6.8 kPa
pCO ₂	7.5 kPa

Which of the following represents the most appropriate management in this case?

- A Ask his wife to decide whether he is to be treated
- B Make a decision that he has a terminal illness and should not be treated
- C Ask your senior to rule on whether resuscitation is appropriate
- D Contact the hospital solicitor to rule with respect to resuscitation
- E Treat with IV naloxone

71071

Submit

Previous Q...

Skip Questi...

E Treat with IV naloxone

Explanation

**E** Treat with IV naloxone

Depression is common in the early stages of Huntingdon's and responds very well to treatment. His wife has given a reliable history that he was depressed at the time of the overdose and, as such, he was not able to make a rational decision to end his life. As such, given the fact that you must act in his best interests, naloxone is the only appropriate next step.

A Ask his wife to decide whether he is to be treated

Although it is desirable to reach agreement with the patient's wife, the final decision to treat rests with you as his doctor. Given the history of depression, you should consider that the overdose was not taken against a background of rational decision making.

B Make a decision that he has a terminal illness and should not be treated

Given the history of depression, you cannot conclude that he made a rational decision to take an overdose of codeine.

C Ask your senior to rule on whether resuscitation is appropriate

This patient has severe respiratory depression, and is at risk of aspiration and type 2 respiratory failure. As such, it's inappropriate to wait for advice from your senior and you should instigate therapy.

D Contact the hospital solicitor to rule with respect to resuscitation

This risks an unacceptable delay, and the view of the solicitor is highly unlikely to be at variance from the need to treat in this patient's best interests.

7/071

Rate this question:      **Next Question**

A 66-year-old man presents to the clinic with his wife. He was started on a selective serotonin-reuptake inhibitor (SSRI) antidepressant 2 weeks ago because of severe depression. His depression appeared to have been triggered by the death of his pet dog, which he had for 15 years.

Calculate

Normal Value

His wife complains that she has not seen any improvement in the 2 weeks he had been on the anti-depressant, and is further worried by the pronouncement in the press that there is an increased suicide rate among patients taking SSRIs.

How would you best advise this couple?

- A He should continue the SSRI
- B He should discontinue the SSRI
- C He should swap the SSRI for a tricyclic anti-depressant
- D There is no increased suicide rate amongst patients taking SSRIs
- E He should proceed to ECT

71072

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- C He should swap the SSRI for a tricyclic anti-depressant
- D There is no increased suicide rate amongst patients taking SSRIs
- E He should proceed to ECT

Explanation



- A He should continue the SSRI**

It is likely that a steady improvement in this patient's symptoms of depression will occur over the next 1-2 weeks. Although increased agitation may be seen, and this is associated with increased risk of suicide, it is usually seen in the first 2 weeks of treatment, and predominantly in adolescents who are treated with SSRIs.

- B He should discontinue the SSRI

There is no reason to discontinue the SSRI given that this patient's mood is likely to improve significantly over the next 1-2 weeks.

- C He should swap the SSRI for a tricyclic anti-depressant

Swapping to a different class of anti-depressant is not appropriate. It's important to counsel the patient and his wife that improvement is likely over the next 1-2 weeks.

- D There is no increased suicide rate amongst patients taking SSRIs

There may be an increase in suicide rate amongst patients under the age of 18 who are prescribed SSRIs.

- E He should proceed to ECT

ECT or swapping to an alternative anti-depressant such as an SNRI is the obvious next step, in the event that there is no improvement over the next 1-2 weeks.

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